POSITION PAPER: Medically Assisted or Rapid Sequence Intubation

DATE: Approved by the Governor's Advisory Board January 28, 2000

Definitions:

Medically Assisted Intubation (MAI): Endotracheal intubation facilitated by sedative / hypnotic medication.

Rapid Sequence Intubation (RSI): Endotrachaeal intubation facilitated by the use of neuromuscular blockade and sedative / hypnotic medication.

Background:

MAI and RSI have been successfully used in the field for the purpose of intubating patients with difficult airways. While more frequent in air programs, ground programs have reported success. However both procedures require the use of medications not commonly administered in the pre-hospital setting. In addition both procedures place the patient at risk until the airway can be established. MAI sedates the patient at risk until the airway can be established. MAI sedates the patient, decreasing any intrinsic airway protection. RSI converts a breathing patient to a patient without respirations. With this in mind, the medical direction committee recommends the following.

1. Review of data from the agency runs must indicate a need for MAI or RSI. This review should distinguish between cardiac arrest or otherwise completely unresponsive patients and those patients with active oropharyngeal reflexes. The former group requires intubation but not RSI or MAI. There must be a sufficient number of potential patients to warrant the training time and effort involved.
2. The OMD for the agency must be familiar with the procedure and willing to provide oversight. The OMD is instrumental in choosing medications used, initial training, continuing education, and back up airway procedure. During the early phases of the program the OMD must be willing to review each case, and to personally participate in the training. .

3. The medical community (other regional OMD's, receiving physicians, ED physicians, and anesthesiologists) shall be advised of the proposed protocol, and supportive. Lack of support by the medical community leads to dissension and places the providers at considerable risk, should a complication occur. Examples of support by the medical community include participation in training, review and development of protocols, and participation in QA activities
4. There must be a written protocol with consideration given for pediatric and geriatric patient or other special considerations.
5. There shall be a well defined program of initial and continuing education in the technique. At minimum this should include an overview of the pharmacology of the medications described in the protocol, descriptive and practical experience in use of the selected back up airway (should the procedure be unsuccessful), and practical skills stations allowing the provider to demonstrate proficiency in performing according to the protocol.
6. The agency must be willing to provide resources for training and continuing education for the procedure. Resources include classroom materials, instructor time, and provider time. While many agencies and providers are eager to participate in the initial training, there is less enthusiasm for follow up, especially if the procedure is used only rarely.
7. The number of providers involved must be small enough to allow close supervision and maintenance of skills. Acceptance in the program should be restricted to experienced ALS providers who have demonstrated proficiency in basic and advanced airway management. Training in techniques for RSI or MAI for new providers should be considered as enrichment only.
8. There must be a strong quality assurance program. This should include at minimum; review of individual and groups of cases for patient selection, adherence to protocol, and rate of success.